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Program Oversight

80.000 PROGRAM OVERSIGHT

This chapter includes information about the processes in place to ensure quality and consistency in the CRS program. It addresses CRS Regional Contractor's financial reporting requirements, program reporting requirements, quality and utilization management requirements, and ADHS/CRS program evaluation activities.

80.100 Financial Reporting Requirements

1. CRS Regional Contractors receiving state funds shall comply with the certified financial and compliance audit provisions of the Office of Management and Budget (OMB) Circular A-128 (or A-133, whichever is applicable) and the certified financial and compliance audit provisions of A.R.S. §35-181.03.

2. CRS Regional Contractors are required to provide ADHS/CRS with financial and cost information, in the manner specified by ADHS. Types of financial reports include:

   A. Cost reports, in the schedules, formats, and timing specified by ADHS/CRS. The cost report must include inpatient, outpatient, and clinic data;

   B. Audit report of CRS Regional Contractor's annual cost reports or financial statements, performed by an independent Certified Public Accountant (CPA);

   C. Third party and family liability and collection reports, submitted in the format specified by ADHS/CRS; and

   D. Other financial, regulatory, or program monitoring reports, as requested by ADHS/CRS for program analysis and oversight.

80.200 Program Reporting Requirements

1. CRS Regional Contractors submit a variety of program reports, and other data to ADHS/CRS to fulfill ADHS/CRS compliance responsibilities to funding agencies, and to assist ADHS/CRS in monitoring and oversight of the CRS program.

2. CRS Regional Contractors shall submit these reports and information in the format and specifications provided by ADHS/CRS.

3. CRS Regional Contractors shall furnish information and records relating to its contract performance to ADHS or ADHS/CRS Program Administration, upon request.

80.300 Program Monitoring and Evaluation Activities

1. CRS Regional Contractors shall design a formal quality management and utilization management (QM/UM) system, and shall implement the system effectively, efficiently, and continually. CRS Regional Contractors shall implement this system to be a coordinated, comprehensive, and ongoing effort to assess and continuously improve the effectiveness of all care and services provided to members.

2. CRS Regional Contractors and their providers shall comply with ADHS/CRS Program Administration in the performance of QM/UM monitoring activities and audits.

3. CRS Regional Contractors and its providers shall develop and implement mechanisms for correcting deficiencies identified through the ADHS/CRS Program Administration's QM/UM monitoring.

4. CRS Regional Contractors shall organize and maintain a QM/UM Committee. The QM/UM committee shall:

   A. Operate under the control of the CRS Regional Contractor's Medical Director;

   B. Include representation from the CRS Regional Contractor's medical and executive management personnel;

   C. Oversee the development, implementation, and revision of the QM/UM plan; and

   D. Allocate qualified QM/UM personnel and sufficient resources to implement the contractor's QM/UM activities.

5. CRS Regional Contractors shall submit a written QM/UM plan to ADHS/CRS for review and approval on an annual basis. If the QM/UM plan is changed during the year, the CRS Regional Contractor shall submit the revised plan before implementation.

   A. The QM plan shall:

      1) Be comprehensive, and evaluate the quality of care and services through the use of quality indicators and other management tools;

2) Indicate the monitoring, evaluation, and improvement of services;

3) Monitor, evaluate, and identify actions to improve availability, accessibility, coordination, and continuity of care provided to members;

4) Reflect the use of indicators consistent with JCAHO (Joint Commission on the Accreditation of Healthcare Organizations) standards, or standards of other applicable nationally recognized accrediting organizations;

5) Contain measurable, objective quality indicators based on benchmarks, to detect the need for program improvement; and

6) Include written procedures for taking appropriate action to improve care when problems are identified.

B. CRS Regional Contractor's UM plan shall define the scope of quality and utilization management activities, including at least the following:

1) Prior authorization of non-emergency hospital admissions;

2) Concurrent review of inpatient stays for members;

3) Discharge planning;

4) Referral management;

5) Retrospective review of hospital claims and services to ensure that hospital covered services are not used unnecessarily or unreasonably;

6) Program and provider audits designed to detect over or underutilization, service delivery effectiveness, and outcome;

7) Medical records audits;

8) Assessment of the adequacy and qualifications of the CRS provider network;

9) Review and analysis of UM data;

10) Enrollment service performance indicators that are objective and measurable; and

11) Other activities necessary to improve the quality of care and the efficient cost effective delivery and utilization of services

C. The UM Plan and Evaluation may be submitted/combined with the

Quality Management Plan.

80.301 Clinical Study

1. The CRS Regional Contractor shall submit annually to ADHS/CRS for approval, a Clinical Study designed to improve member outcomes. Any changes to the approved Clinical Study must also be submitted and agreed to by ADHS/CRS.

2. The Clinical Study shall be written in a format that is easy to understand and contains clearly defined required elements. The required elements include:

   A. Purpose and expected results of the study;

   B. Population to be studied;

   C. Indicators or specific condition(s) of the population that will be studied; and

   D. Analytic plan including use of appropriate statistical tests to be utilized (i.e. chi-squares, averages, t-tests) and valid comparisons to be made (i.e. to a benchmark, to a goal, to results from previous report).

3. The CRS Regional Contractor shall submit annually to ADHS/CRS the results of their Clinical Study for review. The report shall include:

   A. Analysis and comparison completed according to the clinical study plan and include any adjustments to the study plan;

   B. Findings that are clearly presented and understandable; and

   C. Conclusions and interventions that are clearly presented and supported by the findings of the Clinical Study.

80.302 Corporate Compliance

1. CRS Regional Contractors shall:

   A. Have in place, policies and procedures that are capable of preventing, detecting, and reporting fraud and abuse activities.

   B. Report any incident of potential fraud and abuse to ADHS/CRS no later than close of business the day after the incident is discovered.

   C. Submit Fraud and Abuse reports that contain the following

information:

1) Name of member, their date of birth, social security number, and CRS identification number;

2) Date Incident Occurred;

3) Individual Reporting;

4) Site Reporting;

5) Individuals involved in the incident including names of providers, sub-providers, or other individuals involved and their affiliation to the CRS Program;

6) Narrative Description of Issue that includes the Who, What, Where, and When of the issue;

7) Any agencies that were notified. Agencies can include, but are not limited to:

a) Adult Protective Services (APS);

b) Children's Protective Services (CPS);

c) ADHS Licensure;

d) Police;

e) BOMAX;

f) Arizona Board of Nursing; and

8) Corrective actions taken beyond agency notifications.

D. Participate in ADHS/CRS meetings or committees designed to address fraud and abuse issues.

80.303 Member Handbook

1. CRS Regional Contractors shall:

A. Develop, distribute and maintain a Member Handbook.

B. Ensure that the Member Handbook is kept current and contains accurate information.

C. Ensure that handbooks are organized in a style that is easy to follow and contain, at a minimum:

1) A table of contents.

2) A general description about how the CRS Program works, particularly in regards to member responsibilities,

appropriate utilization of services, and CRS Regional Contractor contacts.

3) A description of all available covered services and an explanation of any service limitations or exclusions from coverage. The description should include a brief explanation of the CRS Regional Contractor's approval and denial process.

4) The handbook revision date.

5) How to make, change and cancel appointments.

6) The process of referral to specialists and other providers.

7) What to do in case of an emergency and instructions for receiving advise on getting care in case of an emergency. In a life-threatening situation, the member handbook should instruct members to use emergency medical services (EMS) available and/or activate EMS by dialing 911. The handbook should contain information on proper emergency service utilization, along with how to obtain emergency transportation and medically necessary transportation;

8) Information regarding out of country/out of state moves.

9) Information on grievances, appeals and requests for hearing information that is included in the ADHS/CRS Policy and Procedure Manual (Chapter 60.000).

10) Contributions the member can make towards his/her own health, member responsibilities, appropriate and inappropriate behavior, and any other information deemed essential by the CRS Regional Contractor.

11) Advance directives.

12) Use of other sources of insurance.

13) A description of fraud and abuse (corporate compliance) including instructions on how to report suspected fraud or abuse.

14) Member's right to be treated fairly regardless of race, religion, gender, age or ability to pay.

15) Instructions for obtaining culturally competent materials and/or services, including translated member materials.

16) Information on the availability of printed materials in alternative formats and how to access them.

17) Information on the availability of interpretation services for

oral information at no cost to the member and how to obtain these services.

18) Members' right to know about providers who speak languages other than English.

19) Information on what to do when demographic information changes.

20) Information on how to contact CRS Advocacy Services and a description of its function.

21) Information on how to access after hours care (urgent care).

22) Description of all covered dental services and how to access these services, including the process for making dental appointments.

23) How to obtain, at no charge, a directory of providers.

24) A statement that informs the member that the CRS Regional Contractor does not utilize an incentive plan in regards to the use of referral services.

25) What to do if a members is billed for CRS services.

D. The CRS Regional Contractor shall review the member handbooks at least annually to ensure accuracy of information.

E. A copy of the reviewed and/or revised copy of the CRS Regional Contractor member handbook shall be submitted to ADHS/CRS annually for review and approval.

80.304 Provider Manual

1 CRS Regional Contractors shall:

A. Develop and maintain a Provider Manual;

B. Have Provider Manuals available to all contracted providers; and

C. Submit the Provider Manuals annually to ADHS/CRSA for review and approval.

2. Provider Manuals must:

A. Be organized and in a style that is easy to follow;

B. Contain current information;

C. Contain a signature of the CRS Regional Contractor Administrator indicating their review and approval of the manual;

D. Have a date of the last update;

E. At a minimum include:

1) An introduction to the CRS Regional Contractor who explains their organization and administrative structure;

2) The providers' responsibility and the CRS Regional Contractor's expectations of the providers to include their role in quality and utilization management initiatives;

3) An overview of the CRS Regional Contractor's Provider Service department and function;

4) A listing and description of covered and non-covered services, requirements and limitations;

5) Emergency Room utilization (appropriate and non-appropriate use of the emergency room);

6) Dental services;

7) Referrals to specialists and other providers to include, when applicable, coordination of services with AHCCCS Health Plans/ALTCS Plans and their providers;

8) Claims disputes and hearing rights;

9) Billing and encounter submission information;

10) An indication of the form, UB92, HCFA 1500, or Form C that is to be issued for services;

11) An indication of the fields required for a claim to be considered acceptable by the CRS Regional Contractor;

12) Completed samples of UB92, HCFA 1500, or Form C;

13) CRS Regional Contractor's written policies and procedures which affect the provider(s) and/or the provider network;

14) Claims re-submission policy and procedure;

15) An explanation of remittance advice;

16) Prior authorization requirements;

17) Claims medical review;

18) Concurrent review;

19) Fraud and Abuse;

20) How to access formularies;

21) ADHS/CRS appointment standards,

22) Information on how to obtain educational material and to access interpretation services for members who speak a language other than English, or who use Braille or sign language, and

23) American with Disabilities Act (ADA) requirements when providing services outside the CRS Regional Clinic setting.

80.305 Utilization Management

1 CRS Regional Contractor shall comply with utilization management review and plan requirements.

2 CRS Regional Contractors shall have an ongoing system in place to manage the utilization of CRS services.

3. CRS Regional Contractors shall ensure that management activities are not structured so as to provide inappropriate incentives for denial, limitation or discontinuation of authorization of services.

4. CRS Regional Contractors shall not prohibit providers from advocating on behalf of members within the utilization management process.

80.306 Prior Authorization Policy and Procedure Manual:

1. Prior Authorization policies and procedures must be reviewed annually and updated regularly. The policies and procedures must include:

A. Specific time frames for responding to requests for initial and continued determinations for routine, urgent and emergent requests;

B. An expedited response to requests for authorization of urgently needed services;

C. Practice guidelines that consider the needs of CRS members and:

1) Are approved by ADHS/CRS;

2) Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field;

3) Consider the needs of the members;

4) Are developed and/or adopted in consultation with subcontractors and their contracting health care

professionals;

5) Are disseminated by the CRS Regional Contractors to all affected providers and upon request, to CRS members/guardians; and

6) Provide a basis for consistent decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply.

D. Specify information required for authorization decisions;

E. Process for consulting with the requesting provider when appropriate;

F. A process for clinical review by the CRS Medical Director or physician designee of decisions to deny authorization on the grounds of medical appropriateness and/or medical necessity;

G. The ability of the CRS Medical Director or designee to consult with another appropriately credentialed CRS physician(s) in order to provide an opinion regarding the requested procedure, if the requesting physician challenges the denial;

H. A process, including timeframes, to promptly notify the requesting CRS provider and the member, of any decision to deny, limit, or discontinue authorization of services, through the notice of action process (see section 60.000 Grievance and Appeals);

I. A process for initial authorization of services and/or requests for continuation of services;

J. A process for authorization of emergency services; and

K. A process that allows for hospitals and physicians to notify the CRS provider service office located at each CRS Regional Contractor site within 24 hours from the time the individual appears at the CRS contracted facility/hospital for emergency services. If the date of notification falls on a weekend or holiday, notification shall be made on the first working day following the weekend or holiday.

80.307 Prior Authorization Services

1. The CRS Regional Contractors shall provide prior authorization for the following:

A. All non-emergent inpatient surgeries and medical admissions;

B. Purchase of durable medical equipment and customized adaptive aids (i.e. any orthotic, prosthetic or medical equipment, including wheelchairs that are custom modified);

C. The CRS Regional Medical Director and/or his/her designee may approve requests for replacements;

D. Outpatient diagnostic tests (excluding MRIs) and laboratory services outside the CRS Regional Contractor's existing Sub-contractors;

E. Outpatient PET scans;

F. Non-emergent transportation services between CRS contracted hospitals/facilities approved by the CRS Regional Medical Director or designee;

G. All members scheduled to be seen in a physician/dentist office;

H. Outpatient ambulatory surgery services; and

I. Implantable bone conduction devices and tactile hearing aids (see Chapter 40.600 for further details).

2. All requests for Prior Authorizations are reviewed by the CRS Regional Medical Director or designee.

A. CRS places the responsibility for obtaining prior authorization with the providers. Through the prior authorization process, CRS monitors health care services before they occur so that alternatives or intervention can be coordinated prior to the services being rendered; and

B. The provider/physician is not guaranteed reimbursement with an authorization number. Documentation shall support the claim/service rendered.

3. Prior Authorization review includes the following:

A. Research each request and obtain medical case information as needed in order to certify the CRS medical eligibility for the particular health care service;

B. Verification of the individual's enrollment in the CRS Program;

C. Verification that the services are covered by CRS;

D. Verification of other coverage to which the individual may be entitled, including any requirements for pre-certification by other carriers or liable parties;

E. Determination as to whether the requested services are medically necessary and appropriate;

F. Determination as to whether the medical review requires additional supportive documentation or medical records;

G. Verification that the reviewing site is the proper CRS Regional Contractor to accept payment responsibility for the requested service; and

H. The CRS Regional Contractor's Provider Service Representative will send the authorizations that are completed to the requesting provider/physician and facility on a daily basis.

4. Prior authorization documentation must include the following:

A. The provider and/or physician shall complete the CRS Provider Services Requisition (PSR) form and transmit it to the CRS Regional Contractor Site where the service is to be provided. The CRS Regional Contractor shall be notified as soon as a health care service is planned;

B. The following baseline demographic information shall be provided on the PSR form:

1) Requesting physician and Arizona medical license number,

2) Hospital or other CRS provider,

3) Individual's name and date of birth;

C. Complete service category (inpatient, ambulatory, physician's office);

D. Proposed date of service;

E. Proposed service to be provided;

F. Diagnosis;

G. Narrative description of the indications for the proposed service;

H. Name of surgeon and assistant surgeon (if applicable); and

I. Signature of requesting physician or designee and date of request.

5. Adverse decisions shall only be rendered by the CRS Regional Medical Director or designee.

6. The CRS Regional Contractors need to have a process in place to evaluate the consistent application of review criteria by its prior authorization staff.

80.308 Concurrent Review

1. CRS Regional Contractors will have written policies and procedures in place for the concurrent review process, including:

   A. Procedures to ensure consistent application of the CRS Regional Contractor's review criteria and that decisions are in line with the review criteria;

   B. Timeframes and frequency for conducting concurrent review; and

   C. Sufficient and appropriately qualified staff to provide the timely, knowledgeable reviews.

80.309 Retrospective Reviews/Claims Review

1. The CRS Regional Contractor must complete retrospective reviews for all emergency services.

2. The CRS Regional Contractor must ensure that there are adequate, qualified staff to do the reviews.

3. The CRS Regional Contractor must have a written policy and procedure which includes the following:

   A. Timeframe for when retrospective reviews are done;

   B. Steps or form used for the reviews; and

   C. When and how follow up is done.

80.310 Notice of Action

The CRS Regional Contractor must send a Notice of Action for any denials, termination, suspension or reduction of previously authorized services (see Chapter 60.000 for details).

80.311 Decertification

1. CRS Regional Contractors are to implement a system of utilization review for a member's hospital admission and hospital stay. The purpose of this system is to manage CRS care and monitor the appropriateness of services. The CRS Regional Medical Directors oversee this process.

2. The CRS Regional Medical Director or designee may request that an individual be decertified from a CRS authorized admission (denied coverage of continued hospital days), when a review of the medical record indicates that the hospital stay no longer qualifies as a CRS admission for treatment of a CRS condition.

3. The CRS Regional Medical Director or designee shall review the medical record and notify the CRS provider at least 24 hours before the effective date of a denial of hospitalization coverage. The CRS Regional Medical Director or designee also notifies other responsible parties (member, AHCCCS Health Plan, KidsCare, or other private insurance company) of the effective date of the denial.

4. CRS Regional Contractors are responsible for timely notification to the attending physician that his/her patient has been identified as no longer meeting CRS eligibility requirements, or that there has been a modification of coverage for the hospitalization. ADHS/CRS will not be financially responsible for hospitalization and/or the physician component of care after the date of the denial.

5. All elective and urgent hospital/ambulatory admissions are reviewed by the Regional Contractor's authorization department. If, during the course of admission, continued stay and/or retrospective review, the CRS member is determined medically ineligible, or is ineligible for a particular service or set of services, the following will occur:

   A. CRS Regional Contractor's utilization review staff will review the pertinent information with the CRS Regional Medical Director or designee;

   B. If the CRS Regional Contractor's Medical Director upholds the denial, the authorization status will reflect decertification of continued hospital days or services;

   C. CRS Regional Contractor's utilization review staff will coordinate with the contracting hospitals' Utilization Review Department and Business Office regarding any change in authorization status; and

   D. Written notification of a denial of hospital days or services for a CRS member (decertification) will be mailed to the CRS attending physician and all responsible parties, including the insurance carrier and parent or guardian, within 24 hours prior to the date of discontinued coverage (see Chapter 60.000 for details).

80.312 Discharge Planning

1. The CRS Regional Contractor shall have policies that address discharge planning that includes:

   A. Inpatient discharge planning;

   B. Pediatric to adult transition planning; and

C. Discharge planning for member's exiting the CRS program.

2. For CRS members receiving inpatient services, the CRS Regional Contractor shall:

A. Initiate discharge planning upon the member's hospital admission;

B. Include coordination with all agencies responsible for post-hospital care (e.g., CRS, DES/DDD, AHCCCS, ALTCS, DES/CMDP and DES Adoption Subsidy); and

C. Transfer (Chapter 40.000) and decertify (Chapter 80.311) CRS authorized admissions for the CRS members in accordance with the specific ADHS/CRS policy.

3. For CRS member's exiting the CRS program and/or CRS members who are transitioning to adult services the CRS Regional Contractor shall:

A. Initiate a transition plan by age fourteen (14) which is ongoing until the member leaves the CRS program;

B. Advise the member's primary care provider of the discharge and ensure coordination of the services with the adult primary care provider;

C. Ensure families, members and their primary care providers are part of the development and implementation of the transition plan; and

D. Document the transition plan in the medical record.

4. The CRS Regional Contractor shall notify the member's primary health provider to begin the coordination during the transition of care for the member, 30 days prior to termination of CRS eligibility, or as soon as known if less than 30 days.

80.313 Facility Transfers

1. CRS Regional Contractors may authorize facility transfers for CRS members only under the following conditions:

A. The transfer occurs between CRS contracted facilities;

B. The transfer is for the treatment of a CRS condition;

C. The transfer or transport is ordered and approved by a CRS Regional Contractor's provider; and

D. The transfer or transport is reviewed in advance and authorized by

the CRS Regional Medical Director.

2. The transferring agency must complete applications for transfers, whether verbal or written, and shall include all diagnostic information regarding the CRS condition. The CRS Regional Medical Director or designee reviews the documentation to support the transfer, along with other consultation disclosures, and approves or denies the request for the transfer.

3. If a transfer is approved, and it is subsequently determined that the transferring agency failed to provide complete or accurate information about the member's condition, which resulted in a transfer of a member to treat an ineligible condition, CRS may transfer the member back to the originating facility at the expense of the original transferring agency.

80.314 Referral Management

The CRS Regional Contractor will have a policy and procedure for referral of members to another specialist. Examples for referral include: out of state referrals, second opinions and intersite transfers (see Chapter 40.000).

80.315 Specialty Clinic Availability

The CRS Regional Contractor shall have a policy and procedure that ensures adequate access to care through scheduling of specialty appointments within 45 days. The CRS Regional Contractor will maintain and provide to ADHS/CRS, a detailed list of their providers and their specialties. CRS Regional Contractors must monitor their appointment availability records.

80.316 Drug Utilization Patterns

CRS Regional Contractors shall have policies and procedures for monitoring drug utilization patterns for consistency and availability. CRS Regional Contractors shall have a pharmaceutical formulary.

80.317 Case Management/Care Coordination

1. Care coordination services include:

   A. Coordination of CRS health care through a multi-specialty, interdisciplinary treatment plan; and

   B. Collaboration with providers, communities, agencies, service systems, members, and families.

2. CRS shall provide service coordination, communication and support services designed to manage the transition of care for a member who requires temporary care within an alternative delivery system, or who no

longer meets CRS eligibility requirements.

3. Information regarding CRS services shall be shared timely with all other appropriate professionals, with the member's or family's consent, through discharge planning activities, interdisciplinary team meetings, and service coordination activities.

80.400 Policy and Procedure Manuals

1. CRS Regional Contractor shall develop and maintain a Policy and Procedure manual that includes the following:

   A. A clear title;

   B. Contain a signature of the CRS Regional Contractor Administrator indicating their review and approval of the policy and/or procedure;

   C. The original date of the policy;

   D. The last date the policy or procedure was updated;

   E. The last date the policy or procedure was reviewed; and

   F. Content that is complete and concise.

2. CRS Regional Contractors' Policies and Procedures must be reviewed at least annually.

3. A process for continuous review of personnel and subcontractor performance.

4. CRS Regional Contractors must have Policies and Procedures that cover:

   A. Prior Authorization;

   B. Concurrent review of inpatient stays for members;

   C. Discharge Planning;

   D. Home health agency guidelines for reporting adverse reactions and/or conditions when caring for a CRS Member;

   E. Intersite transfer, out of state services and second opinions (Referral Management);

   F. Retrospective Review;

   G. Claims review regarding medical necessity, appropriateness of

charges;

H. Utilization of covered benefits;

I. Pharmaceuticals for both formulary and non-formulary utilization;

J. Durable medical equipment (DME), including customized and non-customized equipment;

K. Translation/interpretation services;

L. Grievance and Appeals;

M. Fraud and Abuse or Corporate Compliance;

N. Peer Review; and

O. Credentialing along with Re-credentialing.

80.500 Contract Monitoring

CRS Regional Contractors shall agree, as a condition of the CRS Program, that ADHS and any other appropriate agent of the State or Federal Government, or any of their duly authorized representatives, shall have access during reasonable hours to the Regional Contractor's facilities and the right to examine the contractor's books, documents and records involving transactions related to their contract with ADHS/CRS.